Exhibit A

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

P.O. Box 30555
Salt Lake City ,UT 84130-0555

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)	8841
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) EVERETT, THOMAS A	3. PATIENT'S BIRTH DATE MM DD YY / SEX M X F 1975
4. INSURED'S NAME (Last Name, First Name, Middle Initial) EVERETT, DAPHNE	
5. PATIENT'S ADDRESS (No., Street) 196 HART RD	6. PATIENT RELATIONSHIP TO INSURED Self / Spouse X / Child / Other
7. INSURED'S ADDRESS (No., Street)	
CITY: JUDSONIA	STATE: AR
CITY	STATE
ZIP CODE: 72081	TELEPHONE (Include Area Code): ( )
ZIP CODE	TELEPHONE (INCLUDING AREA CODE): ( )
8. PATIENT STATUS Single / Married / Other Employed / Full-Time Student / Part-Time Student	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO
	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M / F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M / F	b. AUTO ACCIDENT? YES / NO PLACE (State)
	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO
	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature on file
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
Signature on file
SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE BECTON, DAVID	17a. I.D. NUMBER OF REFERRING PHYSICIAN B89956	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2861 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 21 05 10 21 05	12		J7195 ANTI-HEMOPHILIC FACTORS	1	80,100.00	1			NDC	58394000101
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER	SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
954855887	X /	4185597	X YES / NO	$ 80100.00	$	$ 80100.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Signature on file SIGNED 6/15/06 DATE		ANCILLARY CARE MANAGEMENT NW 5663 Minneapolis MN 55485 PIN# 303 / 507458 GRP# 104310 / N

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CARRIER

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

8806193245 9100619840059

REDACTED

UNITED HEALTHCARE INSURANCE CO.
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: (866) 204-6096

DATE: 06/20/06
ID #/SSN: S432696060 -6060
EMPLOYEE: DAPHNE EVERETT
CONTRACT: 0702497
BENEFIT PLAN OF: CINTAS CORPORATION

REDACTED

DAPHNE EVERETT
196 HART RD
JUDSONIA AR 72081

SERVICE DETAIL

PATIENT RELAT CLAIM NUMBER	PROVIDER SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
THOMAS SP 6931078201	ANCILLARY CARE PRESCRIPTION DRUGS	10/21/05	80100.00	80100.00				0.00* 0.00	07 QN
		TOTAL	80100.00	80100.00					
					PLAN PAYS ** PATIENT PAYS			0.00 80100.00	
THOMAS SP 6931078101	ANCILLARY CARE PRESCRIPTION DRUGS	07/12/05	80100.00		80100.00 80100.00		100%	80100.00* 80100.00	YL
		TOTAL	80100.00						
					PLAN PAYS ** PATIENT PAYS			80100.00 0.00	

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

++ DEFINITION: +PATIENT PAYS+ IS THE AMOUNT, IF ANY, OWED YOUR PROVIDER. THIS MAY INCLUDE AMOUNTS ALREADY PAID TO YOUR PROVIDER AT TIME OF SERVICE.

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE +SERVICE DETAIL+ SECTION UNDER THE HEADING +REMARK CODE+
(07) THESE CHARGES ARE FOR SERVICES PROVIDED AFTER THIS PATIENT'S COVERAGE WAS CANCELED, THEREFORE, THEY ARE NOT COVERED.
(QN) YOUR CLAIM MAY HAVE BEEN SEPARATED FOR PROCESSING PURPOSES. ANY ADDITIONAL CHARGES WILL BE PROCESSED AS SOON AS POSSIBLE.
(YL) THIS CLAIM HAS BEEN PROCESSED IN ACCORDANCE WITH THE NEGOTIATED CONTRACT RATE.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION	
ANCILLARY CARE	$80100.00

SATISFIED 2005 TO-DATE	IN NETWORK DEDUCTIBLE	IN NETWORK OUT OF POCKET	OUT OF NETWORK - DEDUCTIBLE	OUT OF NETWORK OUT OF POCKET
FAMILY	$400.00	$2810.46	$0.00	$0.00
THOMAS SP	$0.00	$1500.00	$0.00	$0.00
PLAN YEAR 2005	FAMILY: $400.00 INDIV: $200.00	FAMILY: $3000.00 INDIV: $1500.00	FAMILY: $800.00 INDIV: $400.00	FAMILY: $6000.00 INDIV: $3000.00

A REVIEW OF THIS BENEFIT DETERMINATION MAY BE REQUESTED BY SUBMITTING YOUR APPEAL TO US IN WRITING AT THE FOLLOWING ADDRESS: UNITEDHEALTHCARE APPEALS, P.O. BOX 30432, SALT LAKE CITY, UT 84130+0432. THE REQUEST FOR YOUR REVIEW MUST BE MADE WITHIN 180 DAYS FROM THE DATE YOU RECEIVE THIS STATEMENT. IF YOU REQUEST A REVIEW OF YOUR CLAIM DENIAL, WE WILL COMPLETE OUR REVIEW NOT LATER THAN 30 DAYS AFTER WE RECEIVE YOUR REQUEST FOR REVIEW.

YOU MAY HAVE THE RIGHT TO FILE A CIVIL ACTION UNDER ERISA IF ALL REQUIRED REVIEWS OF YOUR CLAIM HAVE BEEN COMPLETED.

INSURANCE FRAUD ADDS MILLIONS TO THE COST OF HEALTH CARE. IF SERVICES ARE LISTED WHICH YOU DID NOT RECEIVE OR SERVICE YOU WERE TOLD WOULD BE FREE, CALL (866) 204+6096.

FURTHER EXPLANATION OF BENEFITS INFORMATION IS ON CONTINUATION PAGE(S)

22EM 06/20/06432696060 0702497 EVERETT,DAPH 196 HART RD 72081 18-M3 M3-02538-004751-EO-06171-K0318-ACN 12K0
0

UNITED HEALTHCARE INSURANCE CO.
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: (866) 204-6096

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REDACTED

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196 HART RD
JUDSONIA AR 72081

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YOU CAN MEET MANY OF YOUR NEEDS ONLINE AT WWW.MYUHC.COM. AT ALMOST ANYTIME DAY OR NIGHT, YOU CAN REVIEW CLAIMS, CHECK ELIGIBILITY, LOCATE A NETWORK PHYSICIAN, REQUEST AN ID CARD, REFILL PRESCRIPTIONS IF ELIGIBLE, AND MORE+ FOR IMMEDIATE, SECURE SELF+SERVICE, VISIT WWW.MYUHC.COM.

HOW TO REGISTER+
YOU CAN REGISTER AND BEGIN USING MYUHC IN THE SAME SESSION. ACCESS WWW.MYUHC.COM TO REGISTER. THE INFORMATION REQUIRED IS ON YOUR INSURANCE ID CARD (FIRST NAME, LAST NAME, MEMBER ID, GROUP NUMBER AND DATE OF BIRTH).

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MAINTAINING THE PRIVACY AND SECURITY OF INDIVIDUALS+ PERSONAL INFORMATION IS VERY IMPORTANT TO US AT UNITEDHEALTHCARE. TO PROTECT YOUR PRIVACY, WE HAVE IMPLEMENTED STRICT CONFIDENTIALITY PRACTICES. THESE PRACTICES INCLUDE THE ABILITY TO USE A UNIQUE INDIVIDUAL IDENTIFIER. YOU MAY SEE THE UNIQUE INDIVIDUAL IDENTIFIER ON UNITEDHEALTHCARE CORRESPONDENCE, INCLUDING MEDICAL ID CARDS (IF APPLICABLE), LETTERS, EXPLANATION OF BENEFITS (EOBS) AND PROVIDER REMITTANCE ADVICES (PRAS). IF YOU HAVE ANY QUESTIONS ABOUT THE UNIQUE INDIVIDUAL IDENTIFIER OR ITS USE, PLEASE CONTACT YOUR CUSTOMER CARE PROFESSIONAL AT THE NUMBER SHOWN AT THE TOP OF THIS STATEMENT.

********** END OF DOCUMENT **********